Applying the Integrated Care Approach:
Practical Skills for the Consulting Psychiatrist
Integrating Behavioral Health and Primary Care: 
*Practical Skills for the Consulting Psychiatrist*

Lori Raney, MD
Anna Ratzliff, MD, PhD
John Kern, MD

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### Integrating Behavioral Health and Primary Care

<table>
<thead>
<tr>
<th></th>
<th>9am</th>
<th>9:15am</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>9am</td>
<td>9:15am</td>
</tr>
<tr>
<td>Mental Health in Primary Care Settings: Collaborative Care</td>
<td>9:15am</td>
<td>10:30am</td>
</tr>
<tr>
<td>Break</td>
<td>10:30am</td>
<td>10:45am</td>
</tr>
<tr>
<td>Practice Consultations and Discussion</td>
<td>10:45am</td>
<td>12:00pm</td>
</tr>
<tr>
<td>LUNCH</td>
<td>12:00pm</td>
<td>1:00pm</td>
</tr>
<tr>
<td>Using Data to Drive Care</td>
<td>1:00pm</td>
<td>2:15pm</td>
</tr>
<tr>
<td>Break</td>
<td>2:15pm</td>
<td>2:30pm</td>
</tr>
<tr>
<td>Leadership Essentials</td>
<td>2:30pm</td>
<td>3:30pm</td>
</tr>
<tr>
<td>Questions and Closing Thoughts</td>
<td>3:30pm</td>
<td>4pm</td>
</tr>
</tbody>
</table>

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### Goals and Objectives

**Mental Health in Primary Care Settings**
- Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care.
- Discuss principles of integrated behavioral health care.
- Describe the roles for a primary care consulting psychiatrist in an integrated care team.
- Apply a primary care oriented approach to psychiatric consultation for common behavioral health presentations.
Introduction to Collaborative Care

Lori Raney, MD

How are we doing?

"I'm afraid you've had a paradigm shift."

Wayne Katon, MD
1950 - 2015

“Provide the most effective care to the most people in need”
Clarify terms:

- **Integrated Care** – Many things to many people addressing physical and behavioral health conditions concurrently in various settings: primary care, community mental health, inpatient, ERs, etc. Many “models” – many not evidence-based but have merit.

- **Collaborative Care** – Sometimes used interchangeably with the term integrated care as a way to describe interaction with other disciplines. Sometimes used as shorthand for the Collaborative Care Model.

- **THE Collaborative Care Model** – Pioneered by Wayne Katon. Has the most robust evidence base of any approach in primary care settings for addressing depression and other psychiatric disorders. Specific core features, psychiatric inclusion needed to reach outcomes, allows accountability for outcomes and cost.

Definition of Collaborative Care

- Collaborative Care is a specific type of integrated care that operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients.

- Collaborative Care is:
  - Population-based care
  - Measurement-based treatment to target
  - Patient-centered and team-based collaboration
  - Evidence-based and practice-tested care
  - Accountable care

Levels of Integration?

Levels of integration vary in the extent to which mental health and primary care settings coordinate, co-locate, and integrate. The levels range from Minimal Collaboration to Transformational Model Integration.

- **Level 1** Minimal Collaboration
- **Level 2** Basic Collaboration at Office
- **Level 3** Basic Collaboration Office
- **Level 4** Close Collaboration Office with Some Integration
- **Level 5** Close Collaboration Aggregating at Inpatient Facility
- **Level 6** Full Collaboration in a Transformational Model Integrated Practice

How many of these people with mental health concerns will see a mental health provider?

Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

Life Span with and Without Mental Disorders


Mental Illness and Mortality

Range of Opportunities for Integrating Care

- Treat Behavioral Health in Primary Care Settings
- Treat General Medical Conditions in Behavioral Health Settings

**Annual Cost of Care**

Common Chronic Medical Illnesses with Comorbid Mental Condition

"Value Opportunities"

<table>
<thead>
<tr>
<th>Patient Groups</th>
<th>Annual Cost of Care</th>
<th>Illness Prevalence</th>
<th>% with Comorbid Mental Condition</th>
<th>Annual Cost with Mental Condition</th>
<th>% Increase with Mental Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Insured</td>
<td>$2,920</td>
<td>10%-15%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td>$5,220</td>
<td>6.6%</td>
<td>38%</td>
<td>$10,710</td>
<td>94%</td>
</tr>
<tr>
<td>Asthma</td>
<td>$3,730</td>
<td>5.9%</td>
<td>35%</td>
<td>$10,030</td>
<td>169%</td>
</tr>
<tr>
<td>Cancer</td>
<td>$11,650</td>
<td>4.3%</td>
<td>37%</td>
<td>$18,870</td>
<td>62%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$5,480</td>
<td>8.9%</td>
<td>30%</td>
<td>$12,280</td>
<td>124%</td>
</tr>
<tr>
<td>CHF</td>
<td>$9,770</td>
<td>1.3%</td>
<td>40%</td>
<td>$17,200</td>
<td>76%</td>
</tr>
<tr>
<td>Migraine</td>
<td>$4,340</td>
<td>8.2%</td>
<td>43%</td>
<td>$10,810</td>
<td>149%</td>
</tr>
<tr>
<td>COPD</td>
<td>$3,840</td>
<td>8.2%</td>
<td>38%</td>
<td>$10,980</td>
<td>186%</td>
</tr>
</tbody>
</table>

Cartesian Solutions, Inc.™ ©

Affordable Care Act 2010

- Insurance Expansion
- Triple Aim Initiatives – better outcomes, lower costs, better experience of care
  - Innovation Grants
  - Collaborative Care
  - Payment Structures
  - Behavioral Health Homes
  - Expand CHC
  - Expand PBHCI
The Collaborative Care Model

- Effective Collaboration
- Informed, Activated Patient
- Caseload-focused Registry review
- Psychiatric Consultation
- Treatment

IMPACT doubles effectiveness of care for depression

50% or greater improvement in depression at 12 months

Participating Organizations

Unützer et al., JAMA 2002; Psych Clin NA 2004
**IMPACT reduces health care costs**

ROI: $6.5 saved / $1 invested

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>4-year costs in $</th>
<th>Intervention group cost in $</th>
<th>Usual care group cost in $</th>
<th>Difference in $</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT program cost</td>
<td>522</td>
<td>0</td>
<td>522</td>
<td></td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>558</td>
<td>787</td>
<td>-210</td>
</tr>
<tr>
<td>Pharmacy costs</td>
<td>7,284</td>
<td>6,942</td>
<td>7,636</td>
<td>-694</td>
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<tr>
<td>Other outpatient costs</td>
<td>14,306</td>
<td>14,180</td>
<td>14,456</td>
<td>-296</td>
</tr>
<tr>
<td>Inpatient medical costs</td>
<td>6,452</td>
<td>7,179</td>
<td>9,757</td>
<td>-2578</td>
</tr>
<tr>
<td>Inpatient mental health/substance abuse costs</td>
<td>114</td>
<td>91</td>
<td>169</td>
<td>-78</td>
</tr>
<tr>
<td>Total health care cost</td>
<td>31,082</td>
<td>29,422</td>
<td>32,785</td>
<td>-3,363</td>
</tr>
</tbody>
</table>


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**Building More Effective Models:**

**Collaborative Care**

**Research Evidence Over 80 Randomized Controlled Trials**

- **Cochrane Review:** Collaborative care for people with depression and anxiety. Archer J et al. 2012: 79 RCTs.
- **Gilbody S. et al. Archives of Internal Medicine; Dec 2006: Collaborative care (CC) for depression in primary care (US and Europe): 37 RCTs.**

Collaborative care is consistently more effective than care as usual.

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**How well does it work in the ‘real world’?**

% with tx response > 50 % improvement in PHQ-9

<table>
<thead>
<tr>
<th>Sample</th>
<th>RESEARCH (RCTs)</th>
<th>USUAL CARE</th>
<th>COLLABORATIVE CARE INTERVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured, middle aged (GHC)</td>
<td>Katon et al. 1993, 1997</td>
<td>40%</td>
<td>70%</td>
</tr>
<tr>
<td>Older adults with chronic</td>
<td></td>
<td>19%</td>
<td>49%</td>
</tr>
<tr>
<td>medical illnesses (IMPACT)</td>
<td>Unutzer et al. 2002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘REAL WORLD’</td>
<td>BASELINE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UW Medicine BHIP (insured)</td>
<td></td>
<td>43%</td>
<td>71%</td>
</tr>
<tr>
<td>WA State MHIP (safety net)</td>
<td></td>
<td>24%</td>
<td>46%</td>
</tr>
</tbody>
</table>
### How Well Does It Work For Other Disorders?

<table>
<thead>
<tr>
<th>Evidence Base Established</th>
<th>Emerging Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Depression</td>
<td>- Substance Use Disorders</td>
</tr>
<tr>
<td>- Adolescent Depression</td>
<td>- ADHD</td>
</tr>
<tr>
<td>- Depression, Diabetes and Heart Disease</td>
<td>- Bipolar Disorder</td>
</tr>
<tr>
<td>- Depression and Cancer</td>
<td></td>
</tr>
<tr>
<td>- Depression in Women's Health Care</td>
<td></td>
</tr>
<tr>
<td>- Anxiety</td>
<td></td>
</tr>
<tr>
<td>- Post Traumatic Stress Disorder</td>
<td></td>
</tr>
<tr>
<td>- Chronic Pain</td>
<td></td>
</tr>
<tr>
<td>- Dementia</td>
<td></td>
</tr>
</tbody>
</table>

- **Depression**
  - Adolescent Depression
  - Depression, Diabetes and Heart Disease
  - Depression and Cancer
  - Depression in Women's Health Care
- **Anxiety**
- **Post Traumatic Stress Disorder**
- **Chronic Pain**
- **Dementia**
- **Substance Use Disorders**
- **ADHD**
- **Bipolar Disorder**

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### Multi-Condition Collaborative Care

- Diabetes nurse educators
- Caseload supervision
- Depression: psychiatrist
- Diabetes and CAD: family doctor
- E-mail to diabetologist for complex cases


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### Evolution of the model: TEAMcare

- **Cost Savings**
  - $600-1100/pt

Care of Mental, Physical and Substance Use Syndromes (COMPASS)

- Depression
- Uncontrolled DM
- Cardiovascular Disease
- Risky Substance Use
- Coming soon!!

NCQA Patient Centered Medical Home 2014 Standards

NCQA 2011

NCMI Standard 1: Enhance Access and Continuity
- Comprehensive assessment includes depression screening for adolescents and adults

NCMI Standard 2: Plan and Manage Care
- One of three clinically important conditions identified by the practice must be a condition related to unhealthy behavior (e.g., obesity) or a mental health or substance abuse condition

NCMI Standard 5: Track and Coordinate Care
- Track referrals and coordinate care with mental health and substance abuse services

www.ncqa.org/

NCQA 2014

Comprehensive Depression Stg
- Screen at least one adolescent or adult for depression

Comprehensive Unhealthy Behaviors Stg
- One of the three conditions identified as important to the practice must be a mental health or substance abuse condition

Comprehensive Mental Health Care Stg
- One of the three conditions identified as important to the practice must be a mental health or substance abuse condition

PCMH Standard 3: Plan and Manage Care
• One of three clinically important conditions identified by the practice must be a condition related to unhealthy behavior (e.g., obesity) or a mental health or substance abuse condition

PCMH Standard 5: Track and Coordinate Care
• Track referrals and coordinate care with mental health and substance abuse services

Telemedicine-based team:
- Nurse care manager – phone
- Pharmacist – phone
- Psychologist – CBT – televideo
- Psychiatrist – televideo if did not respond to trial of 2 antidepressants
- Weekly – whole team met to make recommendations

Payment for Collaborative Care

- Fully capitated
  - Kaiser Permanente
  - VA/DOD
  - Indian Health Service
- Partially capitated: PCP bills FFS; clinics get payment for care management resources
  - Washington State Mental Health Integration Program (CHPW)
  - P4P Incentive
- Value-based payment – pay for performance
- Case rate payment: for Care Management and Psychiatric Consultation
  - DIAMOND Program

Making the ‘business case’ for integrated care

- Savings in total health care costs
  - Demonstrated in research (IMPACT, Pathways)
  - Demonstrated in real world evaluations (Kaiser Permanente, Intermountain)
- Improved patient and provider satisfaction
- Improved provider productivity
  - PCPs have shorter, more productive primary care visits = more visits
  - Mental health consultants in primary care have lower no-show rates
- Improved productivity
  - Reduced absenteeism and presenteeism
  - Higher incomes / net worth
- In safety net populations
  - Reduced homelessness and arrest rates

Performance Measures

- Percent of patients screened for depression
- Percent with follow-up within 2 weeks
- Percent with 50% reduction PHQ-9
- Percent to remission (PHQ-9 < 5 )
- Percent not improving that received case review and psychiatric recommendations
- Percent not improving referred to specialty BH
**Principles of Effective Integrated Behavioral Health Care**

- **Patient Centered Team Care / Collaborative Care**
  - Co-location is not Collaboration. Team members learn to work differently.

- **Population-Based Care**
  - All patients tracked in a registry: no one “falls through the cracks”.

- **Measurement-Based Treatment to Target**
  - Treatments are actively changed until the clinical goals are achieved.

- **Evidence-Based Care**
  - Treatments used are “evidence-based”.

- **Accountable Care**
  - Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

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**BREAK (back in 10 minutes)**

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**Collaborative Care Principles: Practical Primary Care Consultation Skills**

**Anna Ratzliff, MD, PhD**

**Daniel’s Story**

[http://aims.uw.edu/node/300](http://aims.uw.edu/node/300)
**Principles in Action Case Example**

**Patient Centered Team Care / Collaborative Care**
- Co-location is not Collaboration. Team members learn to work differently.

**Population-Based Care**
- All patients tracked in a registry: no one 'falls through the cracks'.

**Measurement-Based Treatment to Target**
- Treatments are actively changed until the clinical goals are achieved.

**Evidence-Based Care**
- Treatments used are 'evidence-based'.

**Accountable Care**
- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

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**Daniel**

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Principle 1: Patient Centered Team Care

Daniel and Angel (PCP)

Daniel and Annie (BHP/CM)
Principle 2: Population Based Treatment

Example: Structured Assessment

BHP/Care Manager is asked to briefly report on each of the following areas:

- Depressive symptoms
- Bipolar Screen
- Anxiety symptoms
- Psychotic symptoms
- Substance use
- Other (Cognitive, Eating Disorder, Personality traits):
  - Past Treatment
  - Safety/Suicidality
  - Psychosocial factors
  - Medical Problems
  - Current medications
  - Functional Impairments
  - Goals

Screening Tools as “Vital Signs”

- Behavioral health screeners are like monitoring blood pressure!
- Identify that there is a problem
- Need further assessment to understand the cause of the “abnormality”
- Help with ongoing monitoring to measure response to treatment
Commonly Used Screeners

<table>
<thead>
<tr>
<th>Mood Disorders</th>
<th>Anxiety Disorders</th>
<th>Psychotic Disorders</th>
<th>Substance Use Disorders</th>
<th>Cognitive Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9: Depression</td>
<td>GAD-7: Anxiety, GAD</td>
<td>Brief Psychiatric Rating Scale</td>
<td>CAGE-AID</td>
<td>Mini-Cog</td>
</tr>
<tr>
<td>MDQ: Bipolar disorder</td>
<td>QIDS-C: PTSD</td>
<td>Positive and Negative Syndrome Scale</td>
<td>AUDIT</td>
<td>Montreal Cognitive Assessment</td>
</tr>
<tr>
<td>CGI: Young Brown</td>
<td>Social Phobia: MDD, OCD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Principle 3: Measurement Based Treatment To Target

Daniel and Anna (Psychiatric Consultant)
ROLE: Caseload Consultant

Caseload Reviews
- Scheduled (ideally weekly)
- Prioritize patients that are not improving

Availability to Consult Urgently
- Diagnostic dilemmas
- Education about diagnosis or medications
- Complex patients, such as pregnant or medical complicated

Common Consultation Questions
Clarification of diagnosis
- Consider re-screening patient
- Patient may need additional assessment

Address treatment resistant disorders
- Make sure patient has adequate dose for adequate duration
- Provide multiple additional treatment options

Recommendations for managing difficult patients
- Help differentiate crisis from distress
- Support development of treatment plans/team approach for patients with behavioral dyscontrol
- Support protocols to meet demands for opioids, benzodiazepines etc...
- Support the providers managing THEIR distress

Assessment and Diagnosis in the Primary Care Clinic
Functioning as a “back seat driver”
- Develop an understanding of the relative strengths and limitations of the providers on your team
- Relying on other providers (PCP and BHP/Care Manager) to gather history

How do you “steer”??
- Structure your information gathering
- Include assessment of functional impairment
- Pay attention to mental status exam
**Uncertainty: Requests for More Information**

- Tension between complete and sufficient information to make a recommendation
- Often use risk benefit analysis of the intervention you are proposing

**Provisional Diagnosis**

- Assessment by BHP and PCP
- Consulting Psychiatrist Case Review or Direct Evaluation
- Screeners filled out by patient
- Provisional diagnosis and treatment plan

**Assessment and Diagnosis in the Primary Care Clinic**

- Diagnosis can require multiple iterations of assessment and intervention
- Advantage of population based care is longitudinal observation and objective data
- Start with diagnosis that is your ‘best understanding’
A Different Kind of Note

Traditional Consult Note

Integrated Care Case Reviews

Note 1: January
Pt still has high PHQ

Note 2: March
Side effects

Note 3 - Pt improved!

Sample Case Review Note

SUMMARY:
Pt is a 28yo male presenting with depression and anxiety. Pt having trouble falling asleep (plays with laptop or phone in bed), sleeping 4-7 hrs/night.

Depressive symptoms: Moderate depression; PHQ-9: 18 Bipolar Screen: Positive screen; May be more consistent with substance use Anxiety symptoms: Moderate to severe; SAD-7: 18 Past Treatment: Currently taking Bupropion and Citalopram (since 1/31) feels more in control, able to think before reacting, less irritable; Bush screen (since 3/31) no evidence of current depression, oil, bipolar or suicide ideation; No evidence of Psychotic symptoms; Denies Paroxetine: Denies Substance use history: History of alcohol use; Engaged in treatment Psychosocial factors: Completed court appointed time in clean and sober housing; Now living back with parents in Carnation; Attending community college; Continues to stay connected to clean and sober housing; Attends Mars Hill Church Other: ADHD: ASRS v1.1 screening – positive; Not diagnosed as a child; Now getting B’s at community college

Medical Problems: of frequent migraines

Current medications: Bupropion HCl (Wellbutrin SR) (Daily Dose: 450mg)
Citalopram Hydrobromide (Celexa) (Daily Dose: 40mg)

Goals: Improve school functioning; Long term goal employment

ASSESSMENT:
Depression NOS, most likely MDD but cannot rule out bipolar disorder; Anxiety NOS; Alcohol dependence, in early sustained remission; no ADHD

RECOMMENDATIONS:
1) Continue to target sleep hygiene
2) Options for antidepressant augmentation. Engage patient in decision making about which ONE option to pursue:
   a. Option 1: Continue Celexa to 20mg as reported sedation on higher dose; Make sure he is taking dose at night and allow for longer period of observation to evaluate efficacy
   b. Option 2: Increase Celexa to 40mg to target anxiety as did not notice a change in sedation but noted increased anxiety when lowered dose
   c. Option 3: Cross taper to fluoxetine: Week 1: Baseline Consider BMP for baseline data in Older adults. Start 10 mg/day. Continue Celexa 20mg. Week 2: Increase dose to 20 mg/day, if tolerated, and stop Celexa. Week 4 and beyond: Consider further titration in 15-20 mg/day increments; typically need higher doses for anxiety. Typical target dosage: 20 mg/day
3) Continue close contact with care coordinator, supporting substance use treatment and behavioral activation.
4) Can consider strattera in the future if poor concentration persists. Would stay on 40 mg/day as combination with Wellbutrin can increase drug level.
‘Disclaimer’ on Note

“The above treatment considerations and suggestions are based on consultations with the patient’s care manager and a review of information available in the care management tracking system. I have not personally examined the patient. All recommendations should be implemented with consideration of the patient’s relevant prior history and current clinical status. Please feel free to call me with any questions about the care of this patient.”

Dr. X, Consulting Psychiatrist
Phone #.
Pager #.
E-mail

If patients do not improve, consider:

- Wrong diagnosis?
- Problems with treatment adherence?
- Insufficient dose / duration of treatment?
- Side effects?
- Other complicating factors?
  - psychosocial stressors / barriers
  - medical problems / medications
  - ‘psychological’ barriers
  - substance abuse
  - other psychiatric problems
- Initial treatment not effective?

Sample Consultations ~ 30 min

<table>
<thead>
<tr>
<th>REASON FOR CONSULTATION</th>
<th>DIAGNOSIS</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Side effects from lithium</td>
<td>BP 1</td>
<td>Switch to valproic acid</td>
</tr>
<tr>
<td>SE from lisdexamfetamine</td>
<td>ADHD</td>
<td>Try another per protocol</td>
</tr>
<tr>
<td>Lithium level is 1.2</td>
<td>BP 1</td>
<td>Continue unless having side effects</td>
</tr>
<tr>
<td>Inc depression symptoms</td>
<td>MDNOS</td>
<td>TSH, if normal start lamotrigine</td>
</tr>
<tr>
<td>Pos SE from quetiapine</td>
<td>BP 1PD</td>
<td>Decrease Seroquel to 100 mg</td>
</tr>
<tr>
<td>Paroxetine not effective</td>
<td>MDD</td>
<td>Add bupropion</td>
</tr>
<tr>
<td>Regular lamotrigine or XR?</td>
<td>BP 2</td>
<td>No difference</td>
</tr>
<tr>
<td>Side effects citalopram</td>
<td>MDD</td>
<td>Switch to bupropion</td>
</tr>
<tr>
<td>Depression symptoms inc</td>
<td>BPT</td>
<td>Check lithium level first, maximize if low, may need to add lamotrigine</td>
</tr>
<tr>
<td>Suicidal, acute distress</td>
<td>PD</td>
<td>Safety plan, DBT referral</td>
</tr>
<tr>
<td>High doses of meds, confused</td>
<td>MDD</td>
<td>Stop hydroxyzine, reduce lorazepam, call collateral</td>
</tr>
<tr>
<td>Anxious, wants</td>
<td>GAD</td>
<td>No alprazolam, increase sertraline,</td>
</tr>
</tbody>
</table>
**Scope of Practice**

What is the environment in which you are consulting and are you comfortable providing support for all these populations?

- Adults
- Children
- Pregnant patients
- Older adults
- Chronic pain
- Substance use treatment

May STRETCH your current scope! Seek consultation from your colleagues.

**ROLE: Direct Consultant**

Seeing patients directly in collaborative care is different than traditional consultation. Approximately 5 – 7% may need this.

Patients pre-screened from care manager population

- Already familiar with patient history and symptoms
- Typically more focused assessment, tele-video OK

Common indications for direct assessment

- Diagnostic dilemmas
- Treatment resistance
- Education about diagnosis or medications
- Complex patients, such as pregnant or medical complicated

**Liability**

Consultation ranges from informal to formal.

- **Informal**: Curbsides, advice to PCP and BHP, no charting, not paid and not supervisor of BHP

- **Combined Collaborative**: Curbside with BHP, document recommendations in chart and may be paid

- **Formal**: Direct with patient, after other steps unsuccessful, written opinion and paid

- **Supervisory**: Psychiatric provider administrative and clinical supervisor of BHP

Collaborative care should reduce risk:

- Care manager supports the PCP
- Use of evidence-based tools
- Systematic, measurement-based follow-up
- Psychiatric consultation

Olick et al. Fam Med 2003
Sederer, el al, 1998
HIPAA

- HIPAA allows sharing of PHI, for the coordination of care, without a signed release.
- The only exception is if there is a stricter state law or if you are a substance abuse treatment facility (42 CFR)

Principle 4: Evidence-Based Treatment

Recommendations: Pharmacological Treatment
STAR-D Summary

Level 1: Citalopram
~30% in remission

Level 2: Switch or Augmentation
~50% in remission

Level 3: Switch or Augmentation
~60% in remission

Level 4: Stop meds and start new
~70% in remission

Rush, 2007

Evidence-based Brief Interventions

- Motivational Interviewing
- Distress Tolerance Skills
- Behavioral Activation
- Problem Solving Therapy
- Modular Anxiety Treatment

Principle 5: Accountable Care
Pay-for-performance cuts median time to depression treatment response in half.

Psychiatrists Best Suited for this Work
- Flexible – expect the unexpected
- Adaptable - child and other populations
- Willing to tolerate interruptions
- Able to manage liability concerns
- Like teaching
- Enjoy being part of a team
- Willing to lead
- **Extending psychiatric expertise to a larger population**

Blessed are the flexible for they shall not get bent out of shape.
'Day in the life' of a part-time primary care consulting psychiatrist

8 AM -12 PM:
- Duties in a community mental health center or other clinical setting:
  - Clinical and administrative
  - Available for urgent curb-side consultations from primary care

12 PM - 1 PM:
- Lunch: 30 min discussion of clinical topic with PCPs during provider meeting.

1 PM - 5 PM:
- Duties as primary care consultant including:
  - Work with BHP/Care managers
  - See patients from caseload
  - Monthly integrated care team meeting for caseload review, QI, and strategic planning

The Art of the “Curbside” Consultation

1. Nicely DONE
   - Build mutual trust and respect: Welcoming tone – “How can I help you?”
     - Offer praise for things done well done
     - Avoid clinical overtones
   - Diagnosis – provisional or confirm:
     - Define chief complaint quickly
     - Assess provider comfort level and abilities
     - Gather additional pertinent information
     - Discuss differential diagnosis and make “best guess” to move forward
     - Respect time constraints; both parties are busy
   - Offer concise feedback and suggestions:
     - Evidence-based pharmacologic and nonpharmacologic ideas
     - Avoid excessive psychiatric jargon
     - Recommend measurement/screening tools
   - Next steps, “if-then” scenarios:
     - Alternate strategies if plan A doesn’t work
     - What could be a next step(s)?
     - Summarize plan before you end call
     - Encourage to call you back if needed
   - Educational component:
     - Tactfully embedded in the consultation
     - Build their confidence and capacity to continue care of the patient
Nicely: Establish and build rapport and trust

- Welcoming tone – “how can I help you?”
- Be readily accessible
- Offer praise for things done well done
- Avoid critical statements

Diagnosis – provisional or confirm

- Define chief complaint quickly
- Assess provider comfort level, abilities and expectations
- Gather additional pertinent information – don’t forget trauma and SUD
- Discuss differential diagnosis and make “best guess” to move forward

Offer concise feedback and suggestions

- Respect time constraints - both parties are busy
- Evidence-based pharmacologic and nonpharmacologic ideas
- Titration plan
- Avoid excessive psychiatric jargon
- Recommend measurement/screening tools
Next steps, “If-then” scenarios

- Alternate strategies if plan A doesn’t work – what could a next step be so do not have to necessarily call you back?
- Summarize plan before you end the call
- Encourage to call back if needed

Educational component

- Tactfully embedded in the consultation
- Build their confidence and capacity to continue care of the patient
- Brief – less than a minute usually

Training Rubric

<table>
<thead>
<tr>
<th></th>
<th>Not Proficient</th>
<th>Partially Proficient</th>
<th>Proficient</th>
<th>Advanced</th>
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<tbody>
<tr>
<td>Trust and rapport building</td>
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<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Gathers additional information</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Offers concise feedback</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Discusses next step scenarios</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Education provided</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
LUNCH
(back at 1pm)

Case Consultation Practice
The Case of Mrs. Jones

Curbside Consultation
Practice
1) TWO People sit back to back:
   - One person has Green Sheet
   - One person has Blue Sheet
2) PCP (Blue Sheet): Read vignette
3) Psychiatric Consultant (Green Sheet): Provide consultation
   - Would you make a recommendation based on the info
     (consider the source - phone vs e-mail)?
   - If not, what additional information would be required
     (tension between uncertainty and requests for more
     information)?
4) Continue on to the next case keeping your same color paper
   - PCP (Green Sheet)
   - Psychiatric Consultant (Blue Sheet)
5) Each person should provide 1-2 consultations
### Advice for the Potential Integrated Care Psychiatrist

**Know the CARE MODEL**

- "Not all PCPs are a fan of collaborative care because they struggle with mental health patients. You have to be creative to find ways of working within the culture of a primary care site."
- "Resist co-location. Watch out for regression to co-location - it sneaks up on the team over and over again."
- "Make sure you understand the different models of integrated care and which are compatible with your interests."
- "Learn to deal with uncertainty and frustration."

**Consider your PERSONAL QUALITIES**

- "Make sure you have the temperament for this work! You must be somewhat outgoing; you must tolerate the interruptions (which are less frequent than you think). This work is SO MUCH FUN if you are the right person for it."
- Essential qualities include "humility and passion and expertise combined flexibly".

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### Advice for the Potential Integrated Care Psychiatrist

**Consider your PROFESSIONAL QUALITIES**

- "Get organized; the same topics come up over and over again so it is helpful to build a library of educational materials to share with care teams."
- Essential qualities are "good communication and interpersonal skills... a basic understanding of primary care medical issues and how they relate to psychiatric comorbidities."
- Essential qualities are "flexible, bright, able to push back on treating psychiatric disorders in a primary care setting."
- "Get creative. Be open to exploring new ways of doing things."
- Essential qualities are "creativity, patience, desire to teach, desire to learn, flexibility, high tolerance for uncertainty."
- Essential qualities are "friendly demeanor, availability, clear concise communication, curiosity and tenacity in pursuit of understanding the patient and relieving their suffering."

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### Accountable Care: Using Data to Shape Care

**John Kern, MD**
Accountability – studying poor retention in my bipolar patients.

Bipolar retention by Mood Disorder type

- Bipolar I
- Bipolar II
- Mood NOS

Does med regimen chosen matter?

Bipolar retention by medication regimen

Are there variations in clinician expertise?

Bipolar retention by BHC

Next step – study how different clinicians care for these patients.
Roles of the Primary Care Consulting Psychiatrist

- **Caseload Consultant**
  - Consult indirectly through care team on a defined caseload of patients in primary care

- **Direct Consultant**
  - Consult directly by seeing selected patients in person or via telemedicine

- **Clinical Educator**
  - Train BHCs and PCPs
  - Both directly and indirectly

- **Clinical Leader**
  - Shape behavioral healthcare for a defined population of patients in primary care
“Everyone Wants to do Integrated Care Until they Learn they have to Change Their Practice”

Everyone wants better, no one wants change.

Two Cultures, One Patient

Primary Care
- Continuity is goal
- Empathy and compassion
- Data shared
- Large panels
- Flexible scheduling
- Fast paced
- Time is independent
- Flexible Boundaries
- Treatment External (labs, x-ray, etc)
- Patient not responsible for illness
- 24 hour communication
- Saved lives
- Disease management

Behavioral Health
- Termination is goal - “discharge”
- Professional distance
- Data private
- Small panels
- Fixed scheduling
- Slower pace
- Time is dependent - “50 min hour”
- Firm Boundaries
- Relationship with provider it’s the patient responsible for participating
- Mutual accountability
- Meaningful lives
- Recovery model
PCPs Embracing the Model

Before Implementation

- This is going to slow me down
- I don’t have time to address one more problem
- This is going to be an anchor
- I already do a good job of treating mental illness

After Implementation

- This takes a load off my plate
- This speeds me up
- I always want to practice like this
- I am giving better care to my patients
- This gives me time to finish my note

“If you aren’t uncomfortable with your practice you aren’t practicing integrated care.” PCP - Colorado

Tips for Working with PCPs

- **Availability and Accessibility**
  - **Easy access** for PCP, unlimited resource for education
  - Same day for outside questions
  - Typically by pager, e-mail, cell phone
  - Not utilized as much as would expect!

- **Selling integrated care**
  - Expect questions and possible skepticism / resistance – "uncomfortable" at first, a little more uncertainty than used to
  - Promote yourself as a resource
  - Resist “regression to co-location”
  - Teach the model
  - Emphasize population approach to utilize scarce resource
  - BHP/Care manager will assess patient first – gatekeeper to psych
  - New role to support the BHP/Care manager and support team treatment
**BHPs/Care Managers - Hire the Right Person!**

Who are the BHPs/CMs?
- Typically MSW, LCSW, MA, RN, PhD, PsyD
- Variable clinical experience

What makes a good BHP/CM?
- Organization
- Persistence - tenacity
- Creativity and flexibility
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team

**CAUTION:**
- Traditional Approach to therapy
- Not willing to be interrupted
- Timid, insecure about skills

**Tips for Working with BHPs/Care Managers**

- **Ask about training**
  - Helpful to know training background and experience of BHP/CM
  - What's in their tool kit?
- **Assess for Strengths**
  - Ability to give concise, organized patient presentations
  - Utilize strong skills to aid in patient care (e.g., if BHP/CM trained in specific therapy modality suggest appropriate application of this skill)
  - Basic medical knowledge
- **Understand Limitations**
  - Can you trust their assessments?
  - Lack of training in a certain area will be an opportunity to provide education
- **Monitor for 'Burnout'**
  - Weekly/frequent consultation allows for early identification of caregiver fatigue
- **Consultation vs Supervision**
  - Consultation focuses on specific case reviews vs supervision including administrative and clinical responsibility for the BHP/Care manager

**‘Silent’ Partners**

- PCP
- Other staff and managers
- BHP/Care Manager
- Consulting Psychiatrist
- Patient
- Additional Clinic Resources
- Core Program
- Outside Resources
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

- Core Program
- Outside Resources
- AIDS
- Outreach
- Counseling
- Substance Abuse
- Vocational Rehabilitation
- CMHC
- Other Community Resources

- Substance Treatment
- Vocational Rehabilitation
- CMHC
- Other Community Resources
Pitfalls

- Do not buy into the plan and do not perform their task – screenings, etc
- Hesitant to address patients – know them in the community, etc
- Do not have buy-in from management/leadership/board

Other Perils and Pitfalls

- Lack of fidelity – sites not using evidence-based approach not accountable for care
- Lack of space
- HIPAA and documentation
- Not enough funding so partial implementation
- Patient engagement

Developing an Integrated Care Program

- Understand the environment
  - The world of primary care
  - Find and nurture a primary care "champion"
- Identify current resources
  - Team building tools
- Create and support your team
- Develop a clinical workflow
- Be sensitive to the unique local resources and culture → Tremendous variability
- We are the “boundary spanners”
Principles of Team-Based Health Care

**Principles**
- Shared goals
- Clear roles
- Mutual trust
- Effective communication
- Measurable processes and outcomes

**Personality Traits**
- Honesty
- Discipline
- Creativity
- Humility
- Curiosity


Elements of High Functioning Integrated Teams

Lardieri, Lasky, Raney. SAMHSA-HRSA CIHS 2014

Effective Implementation: 9 Factors “Secret Sauce”

Table 1: Factors Contributing to Implementation of CCM/CCM

<table>
<thead>
<tr>
<th>Rating</th>
<th>Implementation Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Operating costs of CCM/CCM not seen as a barrier</td>
<td>The clinic has adequate resources to staff patients in the clinic.</td>
</tr>
<tr>
<td>2</td>
<td>Engaged psychiatrist</td>
<td>The consultant psychiatry is responsive to the care manager and is a valuable resource.</td>
</tr>
<tr>
<td>3</td>
<td>Primary care provider PCC “open”</td>
<td>The clinic supports and openness to the care manager.</td>
</tr>
<tr>
<td>4</td>
<td>Strong care manager</td>
<td>The care manager sees the right person for this job and works well in the clinic setting.</td>
</tr>
<tr>
<td>5</td>
<td>Warm healthcare</td>
<td>The healthcare team is friendly and supportive.</td>
</tr>
<tr>
<td>6</td>
<td>Strong leadership support</td>
<td>Clinical and medical group leaders are supportive and hold the project.</td>
</tr>
<tr>
<td>7</td>
<td>Strong PCC champion</td>
<td>There is a PCC in the clinic who actively promotes and supports the project.</td>
</tr>
<tr>
<td>8</td>
<td>Care manager role well defined and implemented</td>
<td>The care manager job description is well defined, with appropriate time, support, and a dedicated space.</td>
</tr>
<tr>
<td>9</td>
<td>Care manager reliability and accessibility</td>
<td>The care manager is present and reliable on the clinic and is available for patients and patient care.</td>
</tr>
</tbody>
</table>

Two Key Areas of Effectiveness
• **Patient Activation and Engagement:**
  - Strong leadership support and a strong physician champion are essential for patient activation into the program.
  - The more well defined and implemented the care manager role, the higher the rate of patient activation.

• **Patients Reaching Remission (PHQ-9 < 5):**
  - The more engaged a psychiatrist was and the more often in-person communication occurred, the more frequently patients experienced remission from their depression.
  - The less likely a group experienced operating costs as a barrier, the more likely their patients were to experience remission.


“Engaged” Psychiatrist
• Do you/care managers **meet routinely with the psychiatrist** for the weekly 2 hour meetings?
• Is the psychiatrist **friendly and helpful with your/our review of patients in your caseload**?
• Does he/she give **feedback, direction, suggestions** for both pharma and other therapeutic approaches to getting the patient to goal?
• Do the **psychiatrist and PCPs ever connect**?
• If the PCP contacts the consulting psych in between the weekly sessions, does he/she typically **get back to the PCP in a timely manner**?
• Has the psychiatrist done any other types of **in-services or education sessions** for your PCPs, your care managers, and/or care teams?
• Do you have any concerns about the consulting psychiatrist working on your team?

Personal communication Nancy (Jaekels) Kamp 2015

Different Flavors of Integrated Care

**TWO IMPORTANT COMMITMENTS:**

- **Measurement-based care** that treats to specific targets and make adjustments until each patient is improved.
- **Population-based care** that tracks all patients in a registry so no one falls through the cracks.

Roles for Psychiatrists

Reflection and Discussion

• Principles Checklist
  – Consider each statement. Do you do this now? Could this be a possible next step?
• Present YOUR goals
• Other Questions?

Resources

• APA “platform” statement
• APA Website: www.psych.org and list serve ksanders@psych.org
• AIMS Center: http://aims.uw.edu
• Center for Integrated Health Solutions: http://www.integration.samhsa.gov/
• ARHQ Integration Academy: http://integrationacademy.ahrq.gov/
• IBHP Partners in Care Toolkit 2013: www.ibhp.org
• Books/e-books:
  • Integrated Care: Working at the Interface of Primary Care and Behavioral Health – edited by Lori Kaney, MD
  • Prevention in Psychiatry – Robert McCarron and colleagues